Women Acting Together for Choices in Health

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List of Acronyms

ACCESS	**Access to Family Planning through Women Managers Project**
AIDS	**Acquired Immune Deficiency Syndrome**
CBD	**Community-Based Distributor**
CBO	**Community-Based Organization**
CEDPA	**The Centre for Development and Population Activities**
CPR	**Contraception Prevalence Rate**
CS	**Child Survival**
DoHS	**Department of Health Services**
ENABLE	**Enabling Change for Women's Reproductive Health Project**
FP	**Family Planning**
FPAN	**Family Planning Association of Nepal**
FRHV	**Female Reproductive Health Volunteer**
HIV	**Human Immunodeficiency Virus**
HMG	**His Majesty's Government of Nepal**
IEC	**Information, Education and Communication**
MIS	**Management Information System**
NGO	**Non-governmental Organization**
RH	**Reproductive Health**
STI	**Sexually Transmitted Infection**
USAID	**United States Agency for International Development**
VDC	**Village Development Committee**
WATCH	**Women Acting Together for Choice in Health Project**

Executive Summary

The Family Planning Association of Nepal (FPAN) received a grant through the ENABLE project in Nepal to implement a community-based reproductive health initiative in Dhanusha and Saptari districts. The initiative is called WATCH. This case study describes the approach to community-based-distributor (CBD) programming being used by FPAN to improve women's health in Nepal's Dhanusha and Saptari districts. It is not intended to be a comprehensive evaluation, but a study to demonstrate which factors contribute to the quality and impact of the performance of a volunteer. FPAN, one of the country's largest non-governmental organizations, is building on a program established under the CEDPA-supported ACCESS Project that relies on female community-based volunteers.

In 1996 the FPAN introduced the Adarsha Byakti concept, a community-based distributor (CBD) program for reproductive health (RH) information and services, designed to develop women leaders who are able to mentor and supervise other women in their communities. These distributors are trained and supported by FPAN to provide an expanded range of reproductive health and child survival services, to forge links with complementary health and development initiatives, and to encourage mobilization of communities in support of improved reproductive health. A basic premise is that, along with access to information and services, individuals need the support of their families and communities to effect long-term behavior changes.

This study was undertaken to help answer the following questions: 1) can programs depend upon volunteers to provide clients with quality services? 2) what factors contribute to the quality and impact of the performance of volunteer community-based distributors (CBDs)? and 3) what motivates a volunteer CBD and how can motivation be supported and sustained?

Interviews with 54 volunteer CBDs and 150 of their clients in Dhanusha District in eastern Nepal describe 1) how training, support, and job satisfaction (acquired through non-monetary rewards) contribute to the quality and impact of performance; 2) how non-monetary rewards for good performance motivate CBDs for community service and lead to continued improvement in the quality of services; and 3) how women's involvement in delivery of information and services promotes an enabling environment that empowers them to seek information and services that meet their needs in their communities.

Findings suggest that FPAN's approach has led to increased utilization of reproductive and related health services and that the CBDs are effective change agents contributing to women's informed decision-making. With the appropriate training and regular supervisory support, female community health volunteers contribute to successful and sustainable improvements in women's demand for and access to quality family planning services and ultimately progress into more influential roles in their communities through which they promote an environment that strengthens women's reproductive health decision-making. Collectively the Adarsha Byaktis constitute a newly created pool of talented women, and they are a key to ensuring the sustainability of CBD services.

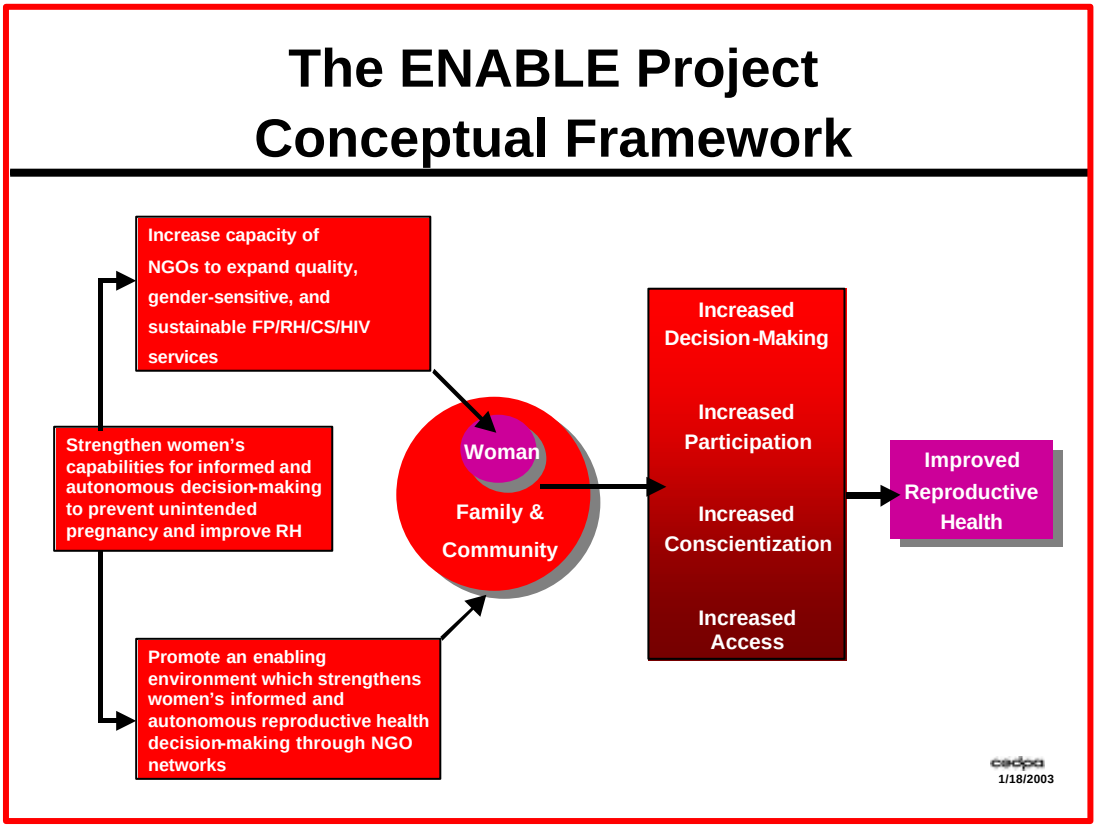
A local artist depicts a community-based volunteer distributing contraceptive pills to her clients.

Introduction

The WATCH Project was implemented in Nepal as part of CEDPA's ENABLE Project (Enabling Change for Women's Reproductive Health). ENABLE is the successor to CEDPA's ACCESS Project (Expanding Women's Access to Family Planning Through Women Managers) that previously worked to improve reproductive health in this area. One important lesson learned while implementing the ACCESS Project is that expanding access to family planning alone is not sufficient to achieve the established family planning objectives. To effectively address client needs, it is necessary to address a range of social, economic, political and cultural factors. Hence, the ENABLE Project was designed to include these factors.

Begun in 1998 in Nepal, India, Ghana, Nigeria, and extended to Senegal in 2001, this five-year project is funded by the U.S. Agency for International Development (USAID) and is being implemented by the Centre for Development and Population Activities (CEDPA). The project aims to strengthen women's capabilities for informed decision-making to prevent unintended pregnancy and improve reproductive health. ENABLE engages women living in communities underserved by the formal healthcare system in advocating, seeking, and receiving a broad range of reproductive health services to meet their specific needs.

Figure 1.



Since 1988, CEDPA has played a leading role in the implementation of community-based family planning (FP) and reproductive health (RH) programs in Nepal by partnering with government bodies and non-governmental organizations (NGO). In 1998, FPAN, with financial and technical support from CEDPA/Nepal, launched the WATCH Project in 90 villages in the plains of eastern Nepal. The WATCH Project contributes to the goals of ENABLE by providing couples with quality community-based FP and RH services. WATCH uses female volunteer to distribute information and services thereby, strengthening women's capabilities for informed decision-making to prevent unintended pregnancy and to improve reproductive health. In all 90 villages FPAN is training female volunteers to provide reproductive health and child survival services, to forge links with complementary initiatives (such as World Education International), and to develop an environment supportive of family planning and other health services.

ENABLE Project Facts

Goal: to strengthen women's capabilities for informed decision-making to prevent unintended pregnancy and improve reproductive health.

Objectives:
(1) expand access to and delivery of quality, gender-sensitive, and sustainable family planning, reproductive health, child survival, and HIV/AIDS prevention information and services; and

(2) promote an enabling environment that strengthens women's informed reproductive health decision-making.

Operational Framework: Programme of Action, International Conference on Population and Development (ICPD).

Reproductive Health and Family Planning in Nepal

His Majesty's Government of Nepal (HMG) recognizes that improvements in the delivery of reproductive health services and the reducing the rate of population growth are critical to the country's survival. The success of the government's strategy depends on empowering women and involving communities in advocating for and delivery of information and services.

The social indicators of Nepal underscore the challenges inherent to providing quality reproductive health services. One of the greatest constraints to development in any sector in Nepal is the poor socio-economic status of women. This is exacerbated by the country's practice of early marriage, first pregnancy immediately after marriage, and inadequate access to reproductive health and family planning services.

One lesson learned while implementing the ACCESS Project was that to effectively address the needs of family planning clients it is essential to address a range of factors that contribute to contraceptive use. For instance, in communities where maternal and child mortality are high, integrating family planning services with maternal health and child survival services has proven to be an acceptable and effective entry point into communities that are generally resistant to FP.

Introductory program to field workers

Despite progress in reducing overall fertility in Nepal, families continue to have more children than the 2.9 average that women indicated to be their desired family size. Approximately 1.2 million out of 4.5 million women of reproductive age report an unmet need for family planning (DoHS, 2000/01). To a large extent, this is due

to lack of access to contraception. Family planning information and services are often just not available in rural communities. Where they are available, socio-cultural practices—such as restrictions against women's mobility—inhibit access.

Selected National Health Indicators

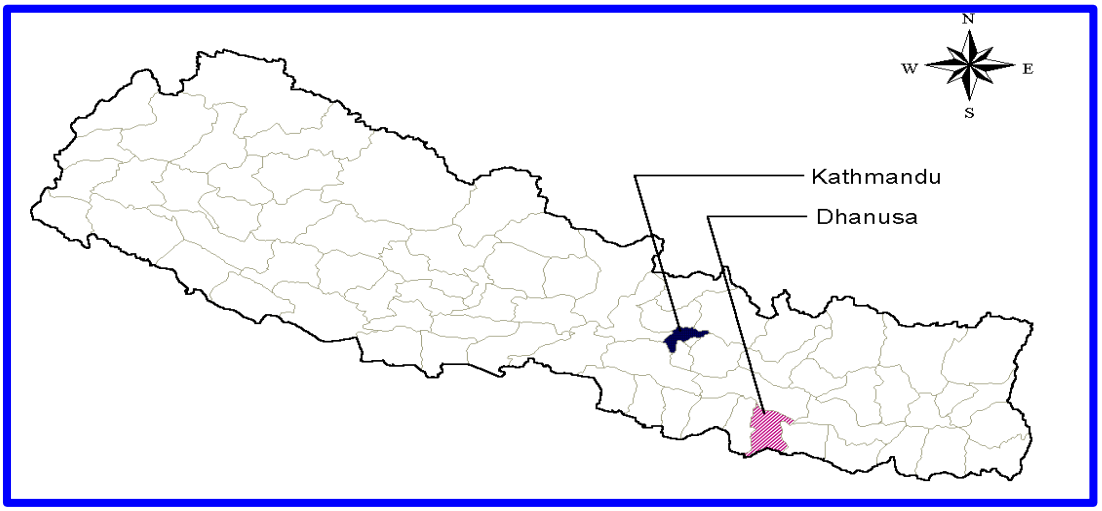
Population Growth Rate:	2.1%
Total Fertility Rate:	4.6
Desired Fertility	2.9
CPR:	34.4%
Unmet Need for FP:	31.4%
Infant Mortality:	78 / 1000
Maternal Mortality:	539 / 100,000

Source: Annual Report (1999 / 2000). DoHS.

Dhanusha District

Dhanusha is one such area. By plane and jeep it takes an entire day of travel from Kathmandu, Nepal's capital city, to Dhanusha District headquarters, a distance of approximately 270 kilometers (168 miles). It can take up to three days to reach some of the villages in this district where services of any kind are very limited.

Figure 2.



Map of Nepal

Dhanusha is overwhelmingly rural and culturally conservative. Farming is the main occupation, but for several months each year a large proportion of the male population migrates to other districts of Nepal or to India in search of wage labor. Most people in Dhanusha are ethnically Maithili or Tharu, indigenous groups with their own languages. The population is predominantly Hindu, although some people are practicing Muslims.

The quality of health care services in the District is poor and maternal and child mortality rates are high. Women are not free to seek and receive services that meet their needs. Traditionally the Maithili and Tharu populations have been resistant to family planning and may contribute to the higher than average fertility rate of 4.7 compared to the national average of 4.64. The District's contraceptive prevalence rate (CPR) in 2000 was 34 percent (DoHS, 1999/2000).

Project Background

Studies, as well as past experiences, have shown that programs utilizing the CBD approach generate a great demand for family planning services. This has been demonstrated in areas of the district previously supported by the ACCESS project. In project Village Development Committees (VDC) the CPR rose from 24.5 percent just five years ago to 43 percent following CBD intervention. In Nepal, CBDs have been able to satisfy a portion of couples unmet contraceptive needs in rural areas and isolated urban settings and have been vital in improving access to RH services.

In 1994, with support from CEDPA's ACCESS Project, FPAN piloted an innovative community-based FP project that aimed to empower women at the grassroots level. FPAN recognized that while Nepal's CBDs had traditionally been male, women prefer female service providers when discussing sensitive RH and FP issues. Therefore, FPAN recruited and trained 450 female volunteers to deliver FP/RH information and services to couples in their communities, in hopes that the counseling female CBDs provided to couples would result in increased utilization of the services now available to them. At the same time, FPAN anticipated that engaging women in the project would help to raise women's self-confidence and status.

In 1996, also under the ACCESS Project, FPAN piloted the Adarsha Byakti training program, which emphasizes the development and encouragement of women to participate actively in community affairs. The aim has been to produce one female community leader—a "guiding light"—in each VDC to serve as a resource person on RH and child survival issues. The program includes a mentoring component that provides an opportunity for women to develop supervisory and communication skills.

In 1998, CEDPA began implementing the three-year ENABLE/WATCH Project in eastern Nepal. Consistent with its objectives, FPAN expanded access to and delivery of gender-sensitive RH services. These services complement the HMG programs in areas where access to the formal healthcare system is limited.

The project covers 90 VDCs (administrative units that are composed of nine communities, known as wards) of which 60 are located in the Dhanusha District and 30 VDCs in Saptari District. However, this study specifically examines the impact of the CBD training model in 30 VDCs in Dhanusha where Adarsha Byaktis had served clients and supervised volunteers for a minimum of two years.

Project Implementation

Recruitment and Training of CBDs

Of the 60 project VDCs in Dhanusha, support for 30 VDCs has been in place since 1994 as part of the ACCESS Project. In 1998, for the 60 new project VDCs (30 in Dhanusha and 30 in Saptari), FPAN recruited and trained 540 female reproductive health volunteers (FRHV)—one woman from each ward.

The training and supervision that CBD volunteers receive are two important factors that contribute to the effectiveness and empowerment of these women. In addition to technical training in reproductive health and child survival disciplines, CBD volunteers receive training in administrative processes (record keeping, monitoring, and reporting procedures) and interpersonal interaction (counseling and communication techniques) to provide them with the skills and confidence they need to influence and counsel couples towards healthy family planning choices.

FRHV Training Program

- Family planning
- Maternal healthcare
- STI / HIV / AIDS prevention
- Child Survival
- Nutrition
- Counseling
- The referral process

***Adarsha Byakti* Program**

The above training, plus:

- In-depth RH and FP
- Safe Motherhood
- Immunization
- Leadership
- Supervisory skills
- Effective communication

Female Reproductive Health Volunteers

The CBD training model used by FPAN is two-tiered. The first-tier CBD volunteers—one FRHV from each ward—are selected on the recommendation of her community. The criteria for selection are that the FRHV must be a married resident of the ward, a continuing contraceptive user, interested in working as a long-term volunteer and, if possible, literate. (While some FRHVs are not literate due to the conservative culture, this does not seem to negatively affect performances.) FRHVs receive five days of training in the areas of family planning, reproductive health, and child survival. In addition, they learn communication skills and practice role-playing to aid in screening and counseling clients. Four days of refresher training are also provided annually. Through training, these unpaid volunteers develop the confidence to participate in and contribute to community FP/RH awareness events.

Adarsha Byaktis

The second-tier of CBDs—only one from each VDC—is chosen by FRHVs and the community after two years of exemplary service as a CBD. In addition to meeting the criteria for FRHV selection, these women must demonstrate leadership potential. Second-tier CBDs receive ten additional days of training designed to provide in-depth knowledge of FP methods. This enables them to dispel misconceptions and to explain the advantages, disadvantages, indications, and precautions for each method of contraception to the clients. The second-tier CBDs also receive management training to prepare them for supervisory roles and learn advocacy skills to build alliances at the community level. Refresher training is conducted annually. These women, known as Adarsha Byaktis ("Ideal Person"), then provide supervisory support to the first-tier CBDs.

A trainer is demonstrating to her class the location of female reproductive organs.

The Adarsha Byakti Program

The Adarsha Byakti training program is designed to develop the skills of women who show leadership qualities to mentor and supervise the eight FRHVs in their VDCs. Adarsha Byaktis report to FPAN supervisors and are paid 100 rupees a month (equivalent to US$ 1.30) for their services.

The Adarsha Byaktis are working with VDC chairmen to establish Community-Based Organizations (CBO), grassroots groups that support and sustain FP activities. CBOs are composed of the VDC chairmen, male members elected by the communities, and Adarsha Byaktis, usually the only female voice in the group. As a member of the CBOs, the Adarsha Byakti is able to secure male involvement and support for women's reproductive health information and services. Further, these groups have access to VDC funds (between 9,000 and 12,000 per VDC for RH programs), provide logistical support to the CBDs to ensure there are adequate FP and RH commodities and foster links from the community to formal healthcare system. In addition to the CBD program, the CBOs fund income generation training and women's development activities.

Initially the Adarsha Byaktis lacked the confidence to even leave their homes or speak to men. However, since the FPAN intervention and encouragement, these women are flourishing. They are breaking down gender barriers, speaking up and participating in community gatherings. Whereas once FRHVs were uncomfortable discussing family planning problems with FPAN male supervisors, the Adarsha Byaktis are bridging the gap.

FPAN provides the Adarsha Byaktis with supervisory support and offers a ladder of career opportunities. Adarsha Byaktis who perform well are invited to the FPAN district office in order to participate in quarterly meetings. As the project has evolved, Adarsha Byaktis have been offered paid employment with FPAN. To date, based on good performance, 12 Adarsha Byaktis have been promoted to positions as Assistant Supervisors, and three to Supervisors.

The Adarsha Byaktis constitute a new pool of talented women, and they are key to ensuring the sustainability of CBD services in their communities.

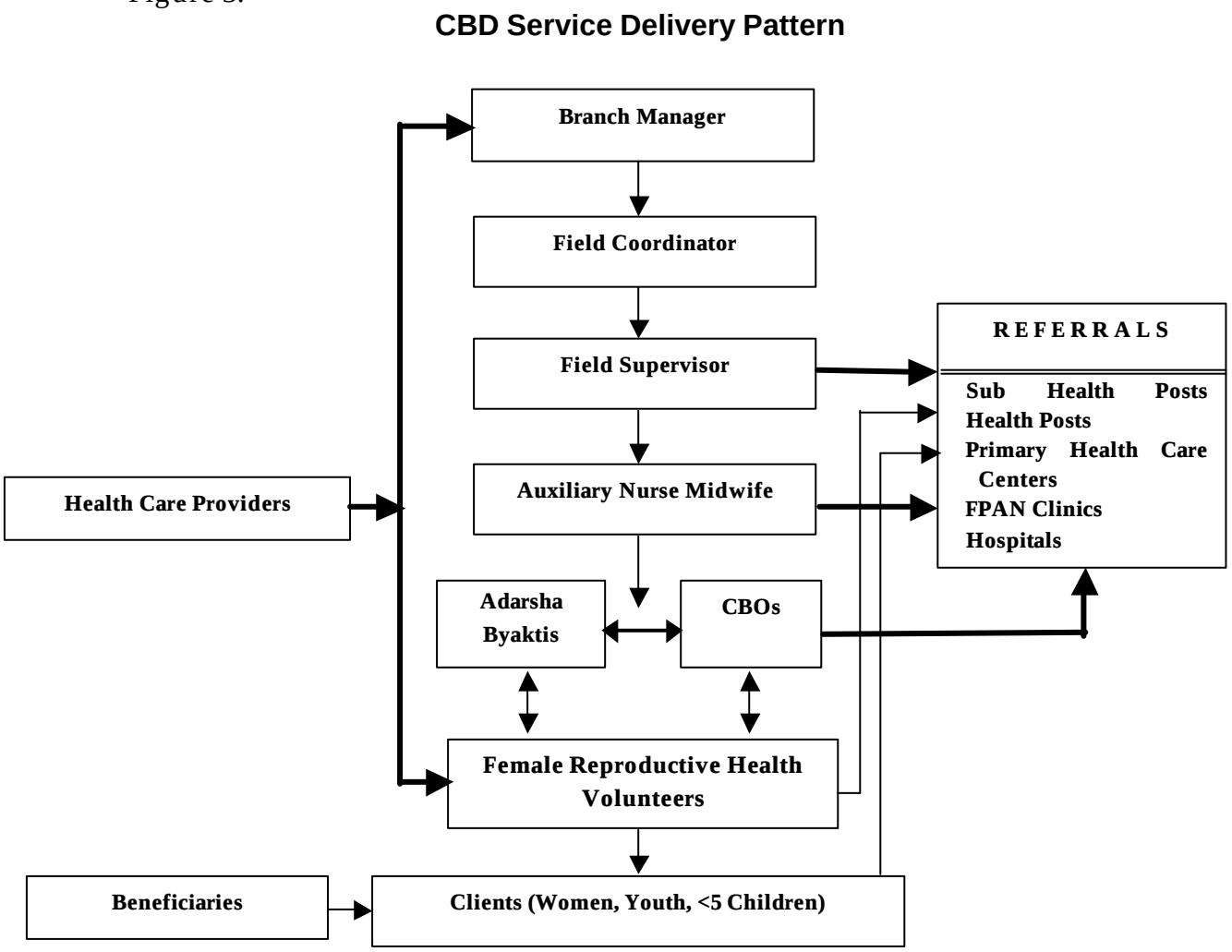
CBD Responsibilities

CBDs, both FRHVs and Adarsha Byaktis, work in their home wards and maintain data on client health behaviors. Using a variety of information, education and communication (IEC) materials, these women visit up to 100 households per month to educate couples about family planning, reproductive health, child survival and STI/HIV/AIDS interventions. They distribute condoms and pills(which FPAN acquires from their own sources) to new FP clients and encourage continuing clients to visit their homes, which serve as posts, for additional information and re-supply of commodities. Clients who choose contraceptive pills are referred to FPAN field supervisors for counseling on possible side effects. CBDs receive extensive training and are able to screen clients using a checklist taken from HMG's Comprehensive Family Planning Manual. Clients who elect clinical contraceptives are referred to government and private clinics, including FPAN-operated clinics.

Bandana Mishra (Adarsha Byakti)

CBDs also work with community leaders to raise public awareness by means of advocacy initiatives, community mobilization, and coalition building to support provisions for improved RH services, as well as for general health and non-health services. For example, through an arrangement with World Education International, 848 women in the project areas have completed basic literacy classes, and 2,728 have completed health education and adult post-literacy classes (FPAN, 1999).

Figure 3.


CBD Service Delivery Pattern
Branch Manager
Field Coordinator
Field Supervisor
Auxiliary Nurse Midwife
Health Care Providers
Adarsha Byaktis
CBOs
Female Reproductive Health Volunteers
Beneficiaries
Clients (Women, Youth, <5 Children)
REFERRALS
Sub Health Posts
Health Posts
Primary Health Care Centers
FPAN Clinics
Hospitals

Project Review

Purpose of the Study

This study, conducted in 30 project VDCs in Dhanusha district between September 1999 and February 2000, examines the impact of FPAN's two-tier training model on family health and reproductive behaviors. Its goal is to determine whether female community health volunteers: (1) contribute to successful and sustainable improvements in women's demand for and access to quality family planning services; and (2) ultimately progress into more influential roles in their communities through which they promote an environment that strengthens women's reproductive health decision-making.

More specifically, it addresses the following questions:

Study Questions

To what extent do the *Adarsha Byaktis* and FRHVs affect recruitment of new contraceptive clients, continuation of contraceptive use, retention and drop-out of clients, and referrals to formal clinical services for maternal and child health services?

To what extent do the *Adarsha Byaktis* and FRHVs influence child health-seeking behavior of their clients, such as immunization and micronutrient supplementation (primarily vitamin A)?

To what extent does the extra training given to Adarsha Byaktis make them better RH, FP, and family health service providers than the FRHVs?

Research Methodology

Sample:
Fifty-four CBDs were selected randomly from 30 VDCs—26 of the 30 Adarsha Byaktis and 28 of the 270 FRHVs. The plan was to study volunteers who had been in place since the ACCESS project (1994)—all 30 Adarsha Byaktis (one from each of the 30 VDCs in the project area) and 30 FRHVs. However, in the end only 26 Adarsha Byaktis and 28 FRHVs (selected using a random sampling frame) participated in the study. At the time of the study, the Adarsha Byaktis had been in their positions for three years and the FRHVs for an average of four years.

Clients of both tiers of CBDs were included in the study. From 422 client names on the Management Information System (MIS) forms, 150 married women of reproductive age (15-49) were chosen for the survey. These women included 74 clients of Adarsha Byaktis and 76 clients of FRHVs.

Data Collection and Instruments: Information was collected from three sources: (1) the MIS forms, (2) surveys of Adarsha Byaktis and FRHVs; and (3) a client survey.

MIS Forms: Forms were available for 422 clients who had received family planning services between June 1997 and June 1999. Data contained in these forms included: (1) date of first client contact; (2) source of client recruitment; (3) initial contraceptive method chosen by client and second method, if switched; (4) confirmed referrals; (5) reasons for client drop-out; and (6) other demographic information.

Surveys of Adarsha Byaktis and FRHVs: In addition to information obtained from the MIS forms, CBDs were interviewed using a structured questionnaire. The survey included open- and closed-ended questions on the demographic background and reproductive health behaviors of the CBDs and their clients.

Client Survey: A structured questionnaire that included open- and closed-ended questions was used to interview clients. Interviews were conducted in the local dialects, as Nepali is a second language for many of the clients.

Findings

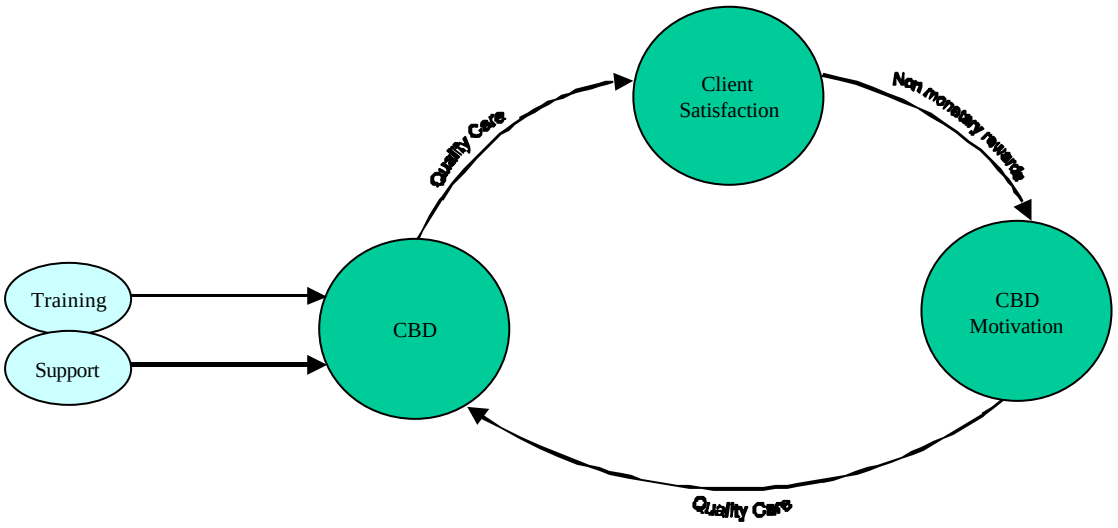
Non-Monetary Rewards

- Gratification from helping other women
- Community recognition
- Improved family relationships
- Heightened impact on family decision-making
- Ability to partake in training
- Supervisory responsibilities
- Opportunities for promotion

This case study contributes to the existing broader body of knowledge and can aid planners in addressing CBD programming questions. It identifies factors that contribute to the quality and impact of the performance of a volunteer CBD; it points out what motivates a volunteer CBD and how motivation can be supported and sustained; and, it suggests that programs can depend upon volunteers to provide clients with quality services.

This study indicates that, initially, the performance and effectiveness of volunteer CBDs depends on the quantity and quality of the training they receive. As time passes, some CBDs gain recognition by their communities for good performances. This recognition, along with other non-monetary rewards, indicates that clients are satisfied with CBD services. (This finding confirms a 1992 study, conducted by CEDPA, that reports good performance leads CBDs to receive non-monetary rewards.) When clients are satisfied with services, CBDs continue to receive additional non-monetary rewards and experience greater job satisfaction. Non-monetary rewards along with encouragement from supervisors are motivators that ensure continuing high-quality performances (see Figure 4).

Figure 4. **Quality of Care and CBD Motivation**



The diagram above demonstrates the cyclical pattern of these findings. The training and strong supervision female volunteers receive contribute to quality of performance, which leads to client satisfaction, as seen by confirmed referrals and duration of use, and satisfied clients lead to rewards (recognition), which motivates CBDs to continuing providing quality care, and eventually to continued client satisfaction (sustainability).

Expand access to and delivery of quality, gender-sensitive, and sustainable FP/RH, child survival and STI/HIV/AIDS information and services.

ENABLE Objective 1

The findings reveal that both tiers of CBDs largely provide their clients with high-quality FP and RH services—"quality" being seen primarily by client satisfaction and measured by continuation rates, confirmed referrals, method switching, and limited dropouts (see Tables 1, 2, and 3 below).

Among new clients recruited, the majority were young women of reproductive age using family planning methods for child spacing. In most cases, CBDs introduced clients to modern family planning methods and to government-sponsored immunization programs, benefiting not only the clients but their families as well.

Recruitment: Over a two-year period (1997-1999), each of the Adarsha Byaktis and FRHVs recruited an average of 20 new clients a year. However, they actually served many more clients, 11 per month in 1998 and 20 a month in 1999, and when counting continuing clients, this is a significant number for one service provider. Both groups were able to reach a large percentage of men (54% of clients chose condoms as their first choice), reflecting their effective communication skills, in either persuading women to discuss reproductive health needs with their partners or speaking with men directly.

Interestingly, Adarsha Byaktis recruited 78 percent more clients than FRHVs, perhaps suggesting that Adarsha Byaktis are better trained than FRHVs to effectively convey the benefits of contraception. The additional ten days of in-depth training in FP is credited for this difference. In addition, Adarsha Byaktis cover a much larger area and are much more mobile than FRHVs, which might also account for the difference.

The majority of clients (64% of Adharsha Byakti clients and 68% of FRHV clients) surveyed reported that they first heard about modern family planning methods through a CBD. This demonstrates the importance of CBDs as contraceptive counselors. Had the CBDs not been active, these new clients may not have become aware of family planning services.

Table 1. Recruitment and Confirmed Referrals (1997-1999)

	Adarsha Byaktis	FRHVs
Number of new clients	270	152
Percentage of males	53%	58%
Total number of referrals	85	39
Number of confirmed referrals	46	11
Percentage of confirmed referrals	54%	28%

Confirmed Referrals: One measure of the quality of counseling can be seen in the number of "confirmed" referrals. Confirmed referrals indicate that clients heeded the advice of the CBD to visit a referral site and actually accepted services. Referral facilities provide clients with stamped verification slips that are maintained by CBDs in their files. Here the Adarsha Byaktis claimed a greater percentage of confirmed referrals, again suggesting that their in-depth knowledge of FP methods and their counseling skills enabled them to recommend a method that better satisfied clients' needs.

In addition, due to their training, both levels of CBDs were able to establish an atmosphere of trust and respect among their clients. These positive first-contact experiences, along with the expectation of similar treatment at the referred facility, created an environment conducive to client follow-through and demonstrate high-quality counseling.

Duration of First Contraceptive Use and Mix of Methods: Information on the length of time clients remained with the first type of contraceptive, prior to switching to another or to discontinuing altogether, is an indicator of client satisfaction and by extension is a reflection of the effectiveness of the service provider's recommendation. Among the 422 newly recruited couples, the average duration of first contraceptive use was 9.8 months, suggesting that the CBDs had a good understanding of their clients' needs as well as a thorough knowledge of the various types of contraceptives. The greater number of Depo Provera clients compared with pill clients indicates that women are selecting a long-term spacing method. In addition, the mix of methods is an indicator of the quality of the services provided by the CBDs. Clients greatly benefited because CBDs were able to match their needs to an appropriate method.

Table 2. Method Mix of Contraceptives

	74 Clients of Adarsha Byaktis	76 Clients of FRHVs
Condoms	51	38
Pills	10	9
Depo Provera	34	51
Norplant	1	0
Female Sterilization	3	1

Continuation: It appears that Adarsha Byaktis were somewhat more effective in retaining individual clients than the FRHVs. Seventy-two percent of Adarsha Byaktis' clients (against 56 percent of FRHVs' clients) benefited from continued contraceptive use. Perhaps because they were better counseled on the pros and cons of each method, couples were able to select a suitable contraceptive the first time around. Again, the quality of the services provided by CBDs can be measured in client satisfaction.

The greatest number of dropouts occurred due to temporary migration. As mentioned earlier, for several months each year a large proportion of the male population migrates in search of wage labor. Dropouts due to side effects (20 percent) were primarily pill users, indicating that clients were well informed about what to expect from their method of choice. Again, this points to the quality of CBD counseling skills.

Table 3. Reasons for Drop-out

Reason for Drop Out	Adarsha Byakti Clients		FRHV Clients	
	Number	Percentage	Number	Percentage
Permanent Migration	2	2.7		
Wants Child	11	14.7	13	19.4
Family Objection	3	4.0	2	3.0
Pregnancy	13	17.3	11	16.4
Side effects	15	20.0	14	20.9
Illness/older age			2	3.0
Temporary Migration	30	40.0	22	32.8
Other	1	1.3	3	4.5
Total	75	100.0	67	100.0

Kalpana Karki

"When I took my baby to the health post, I saw that they were not sterilizing needles. Hundreds of people were there and I knew that these people could die from unsterlized needles. I told them this was dangerous. They said they could not ignite the stove so they could not sterilize the needles. I went home and got my own stove and brought it back to sterilize the needles."

Child Survival Services: Both tiers of CBDs successfully raised awareness surrounding child survival needs. Most clients report they first learned about child survival services from a CBD. The information clients receive influences family participation in government-sponsored immunization and vitamin A programs. Project managers and FPAN supervisors support community use of services by accompanying clients to distribution sites. In addition, data shows that the behavior of a CBD herself is influenced by the training they receive—95 percent of their children have received vitamin A supplements, 97% have been vaccinated against measles, and 100% have been immunized against diphtheria, pertussis and tetanus (DPT vaccine), bacille calmette-guerin (BCG), and polio. The number of children receiving benefits is increasing, an indication of the effectiveness of empowering women for decision-making.

Leadership and Participation in Community Activities: Findings show that both Adarsha Byaktis and FRHVs are involved in activities beyond their CBD responsibilities. Some are leaders of community groups such as Ward committees, mothers' groups, and income generation groups. Both groups facilitate adult literacy classes and both have been principal organizers in community programs such as Condom Day and Literacy Day.

However, findings suggest that Adarsha Byaktis are more active in their communities than FRHVs. As a result of their training they have the confidence to step forward and speak out. Kalpana Karki is one such example. She knew of a health problem and presented a solution. She had the confidence—and the courage—to break with tradition and be heard (see Box on previous page).

AB cycling through their communities delivering commodities

Conclusions

Findings demonstrate that has a positive impact on the quality of services provided by CBDs. With knowledge of family planning alternatives, CBDs are able to match methods with client needs. With strengthened communication skills, CBDs are able to effectively counsel both female and male clients. With strengthened leadership skills, CBDs are confident enough to take on responsible roles in community organizations.

In addition to the success of the WATCH Project in disseminating FP/RH information and services, the FPAN program is opening up opportunities for rural women. Whereas originally there were very few women volunteers, now 100 percent of the CBDs in project areas are women, as are 90 percent of FPAN's field workers, an indication of changes in community norms.

As the CBDs empower their communities with information and services, they acquire a status of their own and, thereby, enable the environment for all women. Due to their elevated status, communities look to them to resolve health-related problems and to advocate for improved health care. In effect, as they are strengthening the environment for women's reproductive health, they are also slowly changing community norms.

A significant finding is the large proportion of male clients who make use of CBD services. As a result of both the visibility of the CBD in the community and the effectiveness of their training, female CBDs are recognized as legitimate health service providers in their communities and are respected by male clients and community elders.

Where differences in CBD effectiveness exist, the differences appear to be related to the amount of training a CBD receives. For example, the Adarsha Byaktis recruited more clients than the FRHVs. Their clients are inclined to remain on their initial contraceptive method longer than clients of FRHVs, and a greater percentage of their clients have confirmed referrals. In these situations the Adarsha Byakti clients appear more satisfied with the services provied than do the clients of the FRHVs, which suggests that the additional training Adarsha Byaktis receive enables them to provide clients with better explanations and recommendations.

Clearly, both tiers of CBDs are contributing to ENABLE/WATCH objectives. They are increasing utilization of a broad range of FP, RH, Child Survival and STI/HIV/AIDS services and are progressing into roles that promote an enabling environment for women's RH decision-making in the communities they serve.

Promote an enabling environment that strengthens women's informed reproductive health decision-making.

Enable Objective 2

Kamala's Story

Kamala Mandal is a former *Adarsha Byakti* who, because of her good performance, has been promoted to the position of FPAN Assistant Supervisor. She tells this story.

A client in her late 30s had been through 11 pregnancies. Although she had heard something on the radio about family planning at a distant health post, she had no idea where to go. After Kamala's counseling, the client decided on pills. When the client's mother-in-law discovered her taking pills, she put a stop to it. The client sought out Kamala, who arranged for her to go to a clinic for Depo Provera shots. The service provider administered the shots even though the clinic was closed.

…Women's informed RH decision-making improves health.

References

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